OPTIMED

PATIENT ADMISSION AND ADMISSION CONSENT FORM

Name - Surname:…… **TR ID No :……**

Gender/Age :…… **Protocol No :……**

Mode of Arrival:…… **Arrival Date Time :……**

Job :…… **Marital Status :……**

Address :……

……..

Home Phone :…… **Mobile Phone :……**

Phone of Patient's Relative: (In case of emergency when the patient is not reached): ……

Hospitalization Department:……

Patient Admitted by :……

Diagnosis of Patient :……

1- I authorize doctors, nurses and other health care professionals to administer the necessary diagnostic interventions and medical treatments that are appropriate for my disease or medical condition by being hospitalized under the authority, observation and method of doctor..... The purposes of the diagnostic procedures and treatments to be performed, alternative treatment methods, possible risks and complications have been explained and my questions have been answered.

2-I/We……..authorize and request Dr…….. to evaluate my complaints which are my/our reason(s) for application completely of my own free will, to perform the examinations and reviews deemed necessary without any restriction, to reach conclusions and to perform the applications deemed appropriate.

3- My doctor, Dr…… has told me/us that there is a disorder related to my/our patient's health condition that can be expressed as…….. and in addition to the statements listed as 15 items in this document, she/he has explained what my disease is, the reasons, frequency of occurrence, what needs to be done for diagnosis and treatment, and the expected and unexpected, more or less dangerous possibilities that may occur during both diagnosis and treatment procedures with treatment alternatives, and has informed me/us and has asked if I/we have consent. I/we fully understand and accept (at my/our own free will) that all these consequences are likely to occur.

4- In addition to the information about my health status/the status of our patient, planned diagnosis and treatment applications at the first application, I/we know, understand, consent and request that different diagnoses can be made by the hospital/doctor and other medical practitioners, different procedures can be performed outside of pre-planned diagnosis and treatment applications, even by different clinics and disciplines, and if deemed necessary, my/our patient's treatment can be continued partially or completely under intensive care conditions and even on the life support unit.

5- I/we know that blood and blood products can be used as whole or part of the applications and that there is a risk of infectious diseases that may be detected in the early or late period, including fever, blood and reactions, shock, kidney failure, serious consequences of blood production stopping due to bone marrow failure, jaundice and AIDS; I/we understand and consent; and I/we request them to be used if necessary.

6- I/we know that intravenous injection can be performed as a whole or part of the application, pain during and after the injection, bruising at the area of the procedure, the needle sticking out of the vein, accumulation of the drug under the skin and in the structures around the vein, blood accumulation around the needle area, pain, redness, swelling, inflammation or formation of clots in the vein as a result of the infection, entry of the needle into the artery, entry of air into the vein and formation of air obstruction, allergy or allergic shock to the medication performed;; I/we acknowledge that this application contain additional risks and hazards in addition to general complications.

7- I/we know that organ or tissue parts may be taken from my/our patient's body as a whole or part of the applications; or foreign surgical materials/equipment such as temporary or permanent metal, synthetic etc. may be used from outside the body, that they may be infected or may not show the expected functions or may be rejected by the body, they may need to be removed again and separate surgeries may be necessary for this; I/We acknowledge that these applications contain additional risks and hazards in addition to general complications.

8- I/we were told, I/we know, I/we understand, I/we accept that the applications may not diagnose all pathologies/diseases related to my health/our patient's health, that the hospital and doctors do not guarantee complete cure for any existing diseases or my/our patient's pathological conditions which have led to this admission whether I recognize it or not, or that new or diseases/pathological conditions may occur due to the diagnostic and treatment procedures.

9- I/We know and approve that treatment applications, including all kinds of diagnostics or surgeries to be performed in relation to this application, may not be completed if deemed necessary or may be divided into multiple sessions and performed in successive separate applications/surgeries or may not be performed at all.

10- All kinds of results that I can encounter are explained to me if I am not treated/if our patient is not treated and I have been clearly and comprehensively explained to that I may encounter events such as infection, blood clotting in the veins and lungs, bleeding at the surgical area or away from the surgical area, allergic reaction, tissue edema, epileptic crisis, temporary or permanent organ or system dysfunction or death in relation to each procedure to be performed during diagnosis and treatment, including meningitis, anaemia, which I know to be common. In addition to other risks, I am aware of side effects such as mild discomfort, numbness in the incision-function area or deformity in the head, arms, legs or body due to permanent scar or removal and addition of bone, deformity in the surgery or body, cerebrospinal fluid from the surgical or functional area, headache or prolonged/chronic pain, temporary or permanent loss of voice due to vocal cord paralysis, temporary or permanent loss of function related to facial, eyebrow, tooth, hearing, swallowing, eye and eye movements, urinary or major abdominal control, or personality, short- or long-term pain and numbness due to disability related to tissue or organ damage or lifetime need to use medication or hormones and positioning during applications. And I accept these risks.

11- In addition to the above mentioned conditions, I have understood and accepted that the risks and dangerous situations mentioned below have been explained to me in a way that I can clearly understand.

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12- I/we know that the procedures to relieve pain with local/regional, spinal, epidural/spinal anesthesia or general anesthesia that can be applied to me/our patient during diagnosis and treatment applications pose an additional risk, and these risks include respiratory problems, drug reactions, uncontrollable high fever, paralysis of any limb or nerve, brain damage and death. I/We understand and approve all these risks.

13- I/We know that medical devices such as X-ray, scopy, ultrasonography, scintigraphy, computerized tomography, magnetic resonance etc. can be applied during diagnosis and treatment applications; I and our patient may be exposed to X-ray, radioisotope/nuclear energy, short and long wave radiation, these applications may lead to unpredictable results including bone marrow suppression and anemia, insufficient defense system, inadequacy of reproductive organs to prevent having children or cancer development even after a long time and I/we approve of their use if deemed necessary.

14- I/We aware that I/we have the right to object to the examination, storage, use, destruction or production of organs or tissues to be removed in any way during the applications related to my/our patient's health, or their images or additional tissues to be produced from them, and all kinds of information to be obtained for scientific purposes and I/we authorize and grant approval.

15- I/We have clearly read the entire written document, including the additions in paragraph 11. It has been clearly read to me/us because I could not read./It has been translated and explained to me/us. I/we have been given the opportunity to ask all kinds of questions and evaluate and make decisions regarding my/our patient's health status both during and after my/our application and while filling out this form. The opportunity to ask all kinds of questions, evaluate and make decisions, including non-treatment was given. It has been explained whether there are any different treatment and diagnostic alternatives, including non-treatment, risks and threats, and we believe that sufficient and satisfactory information has been given to me/us with the answers I have received to my/our questions written in this document and about my/our patient's health and the applications to be performed and I/we consent by signing this form of my/our own free will without any pressure.

Date:……/……/……. Hour:……..:…….

Patient/Patient Relative:

Name-Surname Patient's Date of Birth

Signature:

Doctor Date: ……../……./.....

Name and Surname

Signature:

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Rev.No:00/Rev.Date.:…